STATE OF CONNECTICUT
TEACHERS' RETIREMENT BOARD
765 ASYLUM AVENUE HARTFORD, CT 06105-2822
*"An Affirmative Action/Equal Opportunity Employer"*
Toll Free 1-800-504-1102 (860) 241-8400 Fax (860) 622-2849
www.ct.gov/trb

# APPLICATION FOR SUPPLEMENTAL INSURANCE BENEFITS

## MANDATORY ELIGIBILITY REQUIREMENTS

- Participation in Medicare Part A & B
- A retired teacher collecting a monthly pension benefit from TRB
- Spouse or civil union partner of a retired member
- Surviving spouse or surviving civil union partner of a deceased formerly retired member

## MANDATORY FILING REQUIREMENTS

- Proof of participation in Medicare Part A & B (a Medicare Card or a letter from Social Security providing the Medicare Claim Number and the effective dates for Part A & Part B)
- Copy of a marriage certificate from spouses or civil union license from civil union partners
- One form per enrollee must be received by the 25th of the 2nd month preceding the effective date of coverage.
- NEW RETIREES must provide a debit authorization form. (Premiums must be deducted from a bank account for a minimum of at least the first two months of coverage).
- Surviving spouses and surviving civil union partners of deceased retirees, who are not receiving a pension benefit through TRB, must provide a debit authorization form. (Premiums are deducted monthly from the enrollee's bank account).

## ADD, DROP OR CANCEL TRB COVERAGE

- As a plan participant, you may not add or drop coverage until the next coverage change period, held each October, effective the following January.
- A written cancellation request must be received by the 25th day of the 2nd month preceding the effective termination date. For example, to terminate coverage June 1st, notification must be received by April 25th.
- You will not be allowed to re-enroll in any of the TRB sponsored plans until the next change period.

## Coverage Changes Effective January 1, 2010

The rates on the following page are effective January 1, 2010, paid on or about December 31, 2009.
Premiums will be deducted December 28, 2009 for manually billed accounts.

## PLEASE NOTE:

- DIABETIC SUPPLIES (TEST STRIPS, LANCETS AND MONITORS) should be purchased at a retail pharmacy or a diabetic supply company, who will submit the charges to Medicare for payment.

- Prescription Wigs will be covered by Stirling Benefits beginning January 1, 2010.

- The CT Teacher's Retirement Board (TRB) will coordinate benefits for members who have other health insurance in a fashion consistent with the NAIC coordination of benefit rules. However, since we sponsor a Medicare supplement plan with prescription coverage and receive a federal reimbursement for doing so, we cannot allow a member to participate in our program at the same time that they participate in a Medicare D program, Medicare advance program or the prescription program of another employer who also receives the federal reimbursement. To find out if another prescription program receives the federal reimbursement you must contact the benefits department of the other employer.

- Please inform TRB of any address changes in writing at the above address. We will notify the health plan providers.

- The Delta Dental ID number is 45780003.

**RETAIN THIS IMPORTANT DOCUMENT FOR FUTURE REFERENCE**

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# HEALTH INSURANCE ENROLLMENT FORM
## RETIREE

- Medicare Part A and Part B must be your primary insurance.
- A photocopy of your Medicare Card or a letter from Social Security providing the Medicare Claim # AND effective date of coverage must be submitted with your application.
- One form per enrollee must be received by the 25TH of the 2ND month preceding the effective date of coverage
- As a plan participant, you may not add or drop coverage until the next coverage change period, held in October, effective the following January

I ELECT TO HAVE THE FOLLOWING COVERAGE BECOME EFFECTIVE _____ /01/ _____

| | Cost per person per month | Check one(x) |
|---|---|---|
| Medicare Supplement with Prescriptions | $112.00 | ☐ |
| Medicare Supplement with Prescriptions and Dental | $160.00 | ☐ |
| Medicare Supplement with Prescriptions and Dental, Vision & Hearing | $165.00 | ☐ |
| Cancel all TRB coverage | | ☐ |

If you will retain supplemental coverage other than Medicare A & B and Stirling Benefits, please check this box. ☐

**ALL ENROLLEES MUST PROVIDE THE FOLLOWING INFORMATION:**

| Enrollee's Last Name First Name Initial | | Home Phone |
|---|---|---|
| Street Address City State Zip Code | | |
| Social Security Number | Date of Birth | Email Address |

**PREMIUMS ARE DEDUCTED MONTHLY FROM THE MEMBER'S RETIREMENT BENEFIT.**

| Enrollee's Signature | Date |
|---|---|

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# HEALTH INSURANCE ENROLLMENT FORM
## SPOUSE OR CIVIL UNION PARTNER

- Medicare Part A and Part B must be your primary insurance.
- A photocopy of a marriage license or civil union license is required.
- A photocopy of your Medicare Card or a letter from Social Security providing the Medicare Claim # AND effective date of coverage must be submitted with your application.
- One form per enrollee must be received by the 25TH of the 2ND month preceding the effective date of coverage
- As a plan participant, you may not add or drop coverage until the next coverage change period, held in October, effective the following January

I ELECT TO HAVE THE FOLLOWING COVERAGE BECOME EFFECTIVE _____ /01/ _____

| | Cost per person per month | Check one(x) |
|---|---|---|
| Medicare Supplement with Prescriptions | $112.00 | ☐ |
| Medicare Supplement with Prescriptions and Dental | $160.00 | ☐ |
| Medicare Supplement with Prescriptions and Dental, Vision & Hearing | $165.00 | ☐ |
| Cancel all TRB coverage | | ☐ |

If you will retain supplemental coverage other than Medicare A & B and Stirling Benefits, please check this box. ☐

**ALL ENROLLEES MUST PROVIDE THE FOLLOWING INFORMATION:**

| Enrollee's Last Name First Name Initial | | Home Phone |
|---|---|---|
| Street Address City State Zip Code | | |
| Social Security Number | Date of Birth | Email Address |

**PREMIUMS ARE DEDUCTED MONTHLY FROM THE MEMBER'S RETIREMENT BENEFIT.**

| Enrollee's Signature | Date |
|---|---|

If you are enrolling as the spouse or the civil union partner of a retired teacher or deceased retiree, please furnish the following:

| Retired Teacher's Name | Retired Teacher's Social Security # | Retiree's Signature |
|---|---|---|